

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH:

County.....**Somerset**
 City or town.....**Crisfield**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....**3 years town**
 Hospital, institution, or street address where death occurred:
McCready Memorial Hospital
 How long in hospital or institution?.....**3 da**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....**W. Va**.....County.....**Jefferson**
 City or town.....**Charles Town**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....✓

3. (a) FULL NAME

Robert Matsom Baylor

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Louise Phelps Baylor6. (c) If alive, give age.....**61**.....years

7. Birth date of

deceased (mo., day, yr.)

July 19 1883

8. AGE:

61

Years

8

Months

5

Days

If less than one day

hrs.

min.

9. Birthplace

Chales Town, Jefferson, W. Va
 (Town, county, and state)
Pharmist

10. Usual occupation

11. Industry or business

FATHER

12. Name

Tilden G Baylor

13. Birthplace

Jefferson County, W. Va.

MOTHER

14. Maiden name

Sally Madison Beckwith

15. Birthplace

Jefferson County, W. Va.

16. Informant

Miss Anne Loyd Baylor

Address

Chales Town, W. Va.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mch. 26, 1945

(month) (day) (year)

Cemetery or crematory **Zion Episcopal an Cem.**

Location

Charles Town, W. Va.

18. Funeral director

Address

3/25/45
 (Date rec'd by registrar)**B. C. Collins, M.D.**

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....**mch 24**.....19..**45**.....at **1:30 P**.....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

march 19.....19..**45**.....to **march 24**.....19..**45**.....and that I last saw him.....alive on **march 24**.....19..**45**.....Immediate cause of death.....**acute S. of heart****Coronary atherosclerosis**

DURATION

Due to.....**Carcinoma of P. acinus****metastases to Pan. & Lung**

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of.....

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....Injured at work?.....

23. SIGNATURE.....**George C. Collins, M.D.**.....M. D. or otherAddress.....**Murrow Sts mch**.....Date signed.....**mch 25, 45**

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

CAUSE OF DEATH

DATE OF BIRTH

PROF

EDUCATION

RECEIVED

APR 6 1945

BUREAU V.S.

RELIGION

ETHNIC

STATUS

DATE OF DEATH

PLACE OF DEATH

AGE

CAUSE OF DEATH

PROF

EDUCATION

RELIGION

ETHNIC

STATUS

DATE OF DEATH

PLACE OF DEATH

AGE

ETHNIC

CAUSE OF DEATH

PROF

EDUCATION

RELIGION

ETHNIC

STATUS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

03193

Reg. Dist. No. 260

1. PLACE OF DEATH:

County Somerset

City or town Princess Anne, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

William James Davis

3. (b) Social Security Number

4. Sex M 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife H. Elizabeth Davis

7. Birth date of deceased (mo., day, yr.) September 15, 1875 6.(c) If alive, give age..... years

8. AGE: Years 68 Months 6 Days..... If less than one day..... hrs. min.

9. Birthplace Somerset Co.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name not known

13. Birthplace

14. Maiden name Sarah Covington

15. Birthplace Somerset Co.

16. Informant Litteton Davis

Address Princess Anne Md

17. Burial Date thereof 3-18-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory John Wesley

Location Princess Anne, Md.

18. Funeral director William James & Son

Address Princess Anne, Md.

19. 3/16 45
(Date rec'd by registrar) Registrar J. Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1945 at 6:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10, 1945 to March 13, 1945 and that I last saw him alive on March 12, 1945

Immediate cause of death.....

Chronic Myocarditis 2 yrs

Due to.....

Due to.....

Other conditions Interstitial Nephritis 1 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Clara G. Mawman
M. D. or other

Address Princess Anne, Md. Date signed 3-15-45

MARGIN RESERVED FOR BINDING

VS A15

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3-2)

CERTIFICATE OF DEATH

03194

Reg. Dist. No. 265

1. PLACE OF DEATH:

County... Somerset
 City or town... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 5-6 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... MD County... Somerset
 City or town... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William P Downing

3. (b) Social Security Number

4. Sex... Male 5. Color or race... Colored 6.(a) Single, married, widowed, or divorced... Married
 6.(b) Name of husband or wife... Elda Downing
 7. Birth date of deceased (mo., day, yr.)... March 24, 1876 6.(c) If alive, give age... 67 years
 8. AGE: Years... 39 Months... Days... If less than one day... hrs. ... min.

9. Birthplace... Hatcher Neck Accomac co Va.
 (Town, county, and state)

10. Usual occupation... Oyster opener

11. Industry or business

12. Name... Charles Downing
 13. Birthplace... Accomac co Va

14. Maiden name... Charlotte Dowdy
 15. Birthplace... Somewhere in Virginia

16. Informant... Elda Downing
 Address... Crisfield Md

17. (Burial, cremation, or removal. Which?)... Burial Date thereof... Mar 19 1945
 (month) (day) (year)
 Cemetery or crematory... Lanstonia

Location... Crisfield Md.

18. Funeral director... Chas H Ward
 Address... Marion St Md.

19. (Date rec'd by registrar) 3/16/45 19... C E Collins M.D.
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 3/15 19... 45 at... 6:35 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Feb. 27 19... 45 to... 3/15 19... 45
 and that I last saw him alive on... Feb. 27 19... 45

Immediate cause of death

Cerebral Hemorrhage
Paralysis
 Due to... Cerebral Hemorrhage

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W. J. Barkley M.D. M. D. or otherAddress... 309 W. Mel Ave Date signed... 3/16/45

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MAR 31 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

03195

Reg. Dist. No. 270

1. PLACE OF DEATH: County..... Somerset City or town..... Crisfield (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... 2 da Hospital, institution, or street address where death occurred: McCready Memorial Hospital How long in hospital or institution?.....			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... Ma County..... Somerset City or town..... Ewell Md (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....		
3. (a) FULL NAME Anna Roena Evans			3. (b) Social Security Number		
4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Married	MEDICAL CERTIFICATION		
6. (b) Name of husband or wife T Roosevelt Evans			20. DATE OF DEATH March 28 1945 at 12:15 A.M.		
6. (c) If alive, give age 45 years			21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1945 to March 28 1945 and that I last saw him/her alive on March 27 1945		
7. Birth date of deceased (mo., day, yr.) June 28 1908			Immediate cause of death Pericarditis - virus		
8. AGE: Years 36 Months 9 Days 0 If less than one day..... hrs. min.			DURATION 1 wks		
9. Birthplace Smith Island Somerset Maryland (Town, county, and state)			Due to Chronic pyelonephritis 10 yrs.		
10. Usual occupation Housewife			Due to Chronic nephritis 18 yrs.		
11. Industry or business			Other conditions Chronic colitis 15 yrs.		
12. Name Merrill Tyler			(Include pregnancy within 3 months of death)		
13. Birthplace Smith Island Md			Major findings of operations		
14. Maiden name Mirtie Evans			Date of op.		
15. Birthplace Smith Island Md			Autopsy results		
16. Informant T Roosevelt Evans			PHYSICIAN: Please underline the cause to which death should be charged statistically.		
Address Ewell Md			22. VIOLENCE: If death was due to external causes, fill in the following:		
17. Burial (Burial, cremation, or removal. Which?) Ewell cemetery Date thereof..... April 1 1945 (month) (day) (year) Cemetery or crematory..... Smith Island Md Location.....			Accident, suicide, or homicide..... Date of.....		
18. Funeral director John A Bradshaw Crisfield Md Address			Where did injury occur?..... (City or town) (County) (State)		
19. 3/29/45 (Date rec'd by registrar)			Injured at home, farm, industry, public place (where?).....		
6 E. Collins M.D. Registrar			Means of injury..... Injured at work?.....		
23. SIGNATURE G. M. Payton M.D. Crisfield, Md Address.....			Date signed..... March 29		

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

CERTIFICATE OF DEATH

03196

Reg. Dist. No. 260

1. PLACE OF DEATH:

County SomersetCity or town Princess Anne Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Princess Anne Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John B. Fleming

3. (b) Social Security Number

none

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Saura E. Fleming6. (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.)

Nov. 5, 1855

8. AGE:

Years

Months

Days

If less than one day

89424

hrs.

min.

9. Birthplace Princess Anne Md
(Town, county, and state)10. Usual occupation Retired Farmer

11. Industry or business

FATHER

12. Name

William S. Fleming

13. Birthplace

Princess Anne Md

MOTHER

14. Maiden name

Mary B. Nicholson

15. Birthplace

Princess Anne Md

16. Informant

Mrs Saura E. Fleming

Address

Princess Anne Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

April 1, 1945
(month) (day) (year)

Cemetery or crematory

Presbyterian Cemetery

Location

Princess Anne Md

18. Funeral director

Wale Washell

Address

Princess Anne Md

19.

(Date rec'd by registrar)

19 459/1/45
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30th 19 45 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 _____ to 19 _____

and that I last saw him _____ alive on 19 _____

Immediate cause of death

Acute Dis. of Heart

DURATION

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

9/1/45
Princess Anne Md

M. D. or other

Address

Date signed 3/31-45

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 270

03197
Diat. No. 220

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... City or town..... (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....	
3. (a) FULL NAME Esther Lorrain French		3. (b) Social Security Number	
4. Sex Female		5. Color or race White	
6. (a) Single, married, widowed, or divorced Single		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife		20. DATE OF DEATH..... at	
7. Birth date of deceased (mo., day, yr.) Dec 23 1945		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from	
8. AGE: Years Months Days If less than one day 1 2 15		and that I last saw him alive on	
9. Birthplace Rumblay Somerset Maryland (Town, county, and state)		Immediate cause of death.....	
10. Usual occupation.....		Due to.....	
11. Industry or business		Due to.....	
12. Name John French		Other conditions.....	
13. Birthplace Rumblay Md		(Include pregnancy within 3 months of death)	
14. Maiden name Esther Meredith		Major findings of operations.....	
15. Birthplace Frenchtown Md		Date of op.....	
16. Informant Mrs John French Address Rumblay Md		Autopsy results.....	
17. Burial (Burial, cremation, or removal. Which?) Cemetery or crematory Location John A Bradshaw Address Crisfield Md		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
18. Funeral director Crisfield Md		22. VIOLENCE: If death was due to external causes, fill in the following:	
19. 3/9/45 (Date rec'd by registrar)		Accident, suicide, or homicide..... Date of.....	
20. 6 E Collins M.D. Registrar		Where did injury occur?..... (City or town) (County) (State)	
		Injured at home, farm, industry, public place (where?).....	
		Means of injury..... Injured at work?	
		23. SIGNATURE..... Address..... Date signed.....	

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

03198

Reg. Dist. No. 260

I. PLACE OF DEATH:

County Somerset
 City or town Eden
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? about 50 yrs.
 Hospital, institution, or street address where death occurred:
no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Somerset
 City or town Eden md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Nellie Bly Furniss

3. (b) Social Security Number

no

4. Sex Female 5. Color or race aa 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife George Furniss
 7. Birth date of deceased (mo., day, yr.) about 1884
 8. AGE: Years about 61 Months - Days - If less than one day - hrs. - min. -

9. Birthplace Princess Anne, Somerset Co., Md.
 (Town, county, and state)
 10. Usual occupation Housewife

11. Industry or business Home

12. Name Fortune Woolford

13. Birthplace Somerset Co., Maryland

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant George Furniss
 Address Eden, Maryland

17. Burial Date thereof Mar 4 - 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount Calvary
 Location Baltimore

18. Funeral director James F. Stewart
 Address Baltimore md

19. Dr. J. J. Smith 19. 45
 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 19. 45 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death acute dilatation of heart

Due to acute dilatation of heart

Due to acute dilatation of heart

Other conditions acute dilatation of heart

(Include pregnancy within 8 months of death)

Major findings of operations acute dilatation of heart

Autopsy results acute dilatation of heart

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide no Date of no

Where did injury occur? no (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) no

Means of injury acute dilatation of heart

23. SIGNATURE Wm. M. Woolford MD M. D. or other no
 Address Princess Anne, Md Date signed 3/2/45

CERTIFICATE OF DEATH

NAME OF DECEASED

PLACE OF DEATH

AGE

DATE OF DEATH

SEX

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

NAME OF BURIAL PLACE

NAME OF PHYSICIAN

NAME OF MINISTER

NAME OF FUNERAL HOME

NAME OF CEMETERY

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore, Md.

CERTIFICATE OF DEATH

Reg. Dist. No. 270

03199

270

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
County..... Somerset		(For newborn infants give residence of mother)	
City or town..... Crisfield RURAL		State..... Md County..... Somerset	
(If outside city or town limits, write RURAL and give nearest town)		City or town..... kingston	
How long in above place of death?..... 2 da		(If outside city or town limits, write RURAL and give nearest town)	
Hospital, institution, or street address where death occurred:		Street No.....	
McCready Memorial Hospital		(If rural, give LOCATION)	
How long in hospital or institution?.....		2.(a) If veteran, name war.....	
3.(a) FULL NAME		3.(b) Social Security Number	
Bettie Esther Gray			
4. Sex		5. Color or race	
Female		White	
6.(a) Single, married, widowed, or divorced		MEDICAL CERTIFICATION	
Single		20. DATE OF DEATH..... Mch 18 1945	
6.(b) Name of husband or wife.....		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from	
6.(c) If alive, give age..... years		Mch 15 1945 to Mch 18 1945	
7. Birth date of deceased (mo., day, yr.)		and that I last saw him..... alive on..... Mch 18 1945	
Dec 21 1943		Immediate cause of death.....	
8. AGE: Years Months Days		Acute myocardial infarction	
1 3 27		Due to.....	
If less than one day		Coronary	
hrs. min.		Due to.....	
9. Birthplace.....		DURATION	
Kingston Somerset Maryland			
(Town, county, and state)			
10. Usual occupation.....			
None			
11. Industry or business.....			
12. Name.....			
Harvey Gray			
13. Birthplace.....			
Kingston Md			
14. Maiden name.....			
Bettie Fry			
15. Birthplace.....			
Greensboro W Va			
16. Informant.....			
Bettie Gray			
Address.....			
Kingston Md			
17. Burial.....			
(Burial, cremation, or removal. Which?)			
Date thereof.....			
Mch 20 1945			
(month) (day) (year)			
Cemetery or crematory.....			
Holly Grove cemetery			
Location.....			
Westover R F D #1			
18. Funeral director.....			
John A Bradshaw			
Address.....			
Crisfield Md			
19. (Date rec'd by registrar).....			
3/20 1945			
Registrar.....			
T. B. Callahan M.D.			
23. SIGNATURE.....			
Guy C. Ouborn			
M. D. or other			
Address.....			
Deputy registrar etc. M.D.			
Date signed.....			
Mch 19 45			

CERTIFICATE OF MAIL

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

DATE: [illegible]
TIME: [illegible]
PLACE: [illegible]

POSTAGE PAID BY ADDRESSEE

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APR 6 1945
BUREAU V.S.

APR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

CERTIFICATE OF DEATH

Reg. Dist. No. 269

1. PLACE OF DEATH:

County SomersetCity or town Crusade Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County SomersetCity or town Crusade Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Issac Henry Hickman4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Harriet E. Hickman7. Birth date of deceased (mo., day, yr.) May 8, 1883 6.(c) If alive, give age 37 years8. AGE: Years 61 Months 10 Days 15 If less than one day _____ hrs. _____ min.9. Birthplace May 8, 1883
(Town, county, and state) Farmer10. Usual occupation Farmer11. Industry or business Truck Driving12. Name William Hickman13. Birthplace Crusade Md.14. Maiden name Charlotte Phoebeus15. Birthplace Crusade Md.16. Informant Mrs. Chere MorrisAddress Princess Anne Md.17. Burial (Burial, cremation, or removal, which?) March 23, 1945
(month) (day) (year)Cemetery or crematory St. AndrewsLocation Princess Anne Md.18. Funeral director Dale RashellAddress Princess Anne Md.19. Mon 20 1945 Wm. J. Borell
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

218-05-8778

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945 at 11:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1942 to March 19 1945
and that I last saw him alive on March 19 1945

Immediate cause of death _____

carcinoma of stomach

DURATION

1 year

Due to _____

Due to _____

Other conditions arterio sclerosis
heart disease

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank H. H. H.Address Princess Anne M. D. or other _____Date signed 3/28/45

RECEIVED
APR 4 1965
BUREAU T.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of residence of deceased is shown on **MARYLAND STATE DEPARTMENT OF HEALTH**
2411 N. Charles St., Baltimore

03201

268

Reg. Dist. No.

CERTIFICATE OF DEATH

FILE No. G 94 MAY 15 1945

1. PLACE OF DEATH:

County Somerset Co.City or town Venton, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Venton
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Alexander Holbrooke

3. (b) Social Security Number

4. Sex M 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mary Frances Holbrooke7. Birth date of deceased (mo., day, yr.) March 30, 1872 8. (c) If alive, give age 72 years8. AGE: Year 72 Month 11 Days 27 If less than one day
hrs. min.9. Birthplace Venton, Md.
(Town, county, and state)10. Usual occupation farmer

11. Industry or business

12. Name Stanley Holbrooke13. Birthplace Somerset Co.14. Maiden name Ella Hitch15. Birthplace Somerset Co.16. Informant George Thomas MaddoxAddress Venton, Md.17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 3-30-1945
(month) (day) (year)Cemetery or crematory Venton, Md.Location Venton, Md.18. Funeral director Wilbur James & SonAddress Princess Anne, Md.19. 3/29 19 45 Registrar J. Smith

(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 19 45 at 11:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 19 45 to March 26 19 45
and that I last saw him alive on March 26 19 45Immediate cause of death Pulmonary tuberculosis DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Matthews M. D. or otherAddress Princess Anne Date signed 3/27/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
APR 6 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03202

Reg. Dist. No. 262

1. PLACE OF DEATH:

County **Somerset**
City or town **Pocomoke City, RURAL**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **7 months & 21 days**
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State **Maryland** County **Somerset**
City or town **Pocomoke City, RURAL**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **# Rt. 1**
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Robert Lewis Joyner

3. (b) Social Security Number

4. Sex **Male** 5. Color or race **Colored** 6.(a) Single, married, widowed, or divorced **Single**

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) **August 4, 1944** 6.(c) If alive, give age years

8. AGE: Years **7** Months **21** Days **hrs.** min.

9. Birthplace **RURAL, Pocomoke City-Somerset-Md.**
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name **John Joyer** 13. Birthplace **North Carolina**

MOTHER 14. Maiden name **Mabel Horsey** 15. Birthplace **Somerset County, Md.**

16. Informant **Mabel Horsey Joyner**
Address **Pocomoke City, Md. # Rt. 1**

17. Burial **Burial** Date thereof **Mar. 27, 1945**
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory **Christ M. E. Cemetery**
Location **Pocomoke City, Md. Rt. 1**

18. Funeral director **H. Harvey Bradshaw**
Address **Pocomoke City, Md.**

19. **Mar. 27** 19 **45** **Mrs Clayton Harris**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **March 26** 19 **45** at **10 A** M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from **March 25** 19 **45** to **March 26** 19 **45**
and that I last saw him alive on 19

Immediate cause of death

Sudden Collapse DURATION **1/2 hr**

Due to

Base Pneumonia **2 dy**

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **J. Williams** M. D. or other **3/27/45**

Address **Pocomoke City** Date signed

MARGIN RESERVED FOR BINDING

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

RECEIVED
APR 5 1945
BUREAU V.F.

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NOTICE TO THE PUBLIC

RECEIVED
APR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 70

CERTIFICATE OF DEATH

03264

Reg. Dist. No. 260

1. PLACE OF DEATH:

County Somerset
 City or town Princess Anne
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 66 yr
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Somerset
 City or town Princess Anne
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D. 1
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Ellen Frances Miles

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed8.(b) Name of husband or wife William R. Miles7. Birth date of deceased (mo., day, yr.) Dec 12-1878 6.(c) If alive, give age years8. AGE: Years 66 Months 3 Days 11 If less than one day hrs. min.9. Birthplace Princess Anne Somerset MD
(Town, county, and state)10. Usual occupation House work

11. Industry or business

12. Name Chas Milbourn13. Birthplace Princess Anne Somerset MD14. Maiden name Matilda Mc Bride15. Birthplace Princess Anne Somerset MD16. Informant Viola LongAddress Princess Anne R.F.D. 1 MD17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Mar 27-45
(month) (day) (year)Cemetery or crematory Oak HillLocation Princess Anne MD18. Funeral director Chas H WardAddress Marion Sta19. 3/26 19 45 Registrar Frank
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 19 45 at 49 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 18 19 45 to Feb 18 19 45and that I last saw him alive on Feb 15 19Immediate cause of death unknown
"Sudden Death"

DURATION

Due to Coronary Failure S.S.Due to Generalized AtherosclerosisOther conditions Chronic Bronchitis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank

M. D. or other

Address Princess AnneDate signed 3-23/45

WILLIAM H. HARRIS, JR. STATE CHIEF OF POLICE

CHIEF OF POLICE

RECEIVED

APR 6 1945

BUREAU V.S.

U.S. DEPARTMENT OF JUSTICE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03205

Reg. Dist. No.

269

1. PLACE OF DEATH:

County SomersetCity or town Oriskany, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Oriskany, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Sally C. Ross

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Charles Ross6. (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.)

Dec. 18, 1858

8. AGE:

Years

Months

Days

If less than one day

85217

hrs. min.

9. Birthplace Baltimore Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name William Wyatt13. Birthplace Baltimore Md.14. Maiden name Alexina Hubbard15. Birthplace Baltimore Md.16. Informant Philip WyattAddress Oriskany, Md.17. Buried Date thereof March 10, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Mount AiryLocation Mount Airy18. Funeral director Dale DashiellAddress Princeton, Md.19. 4/10 19 40 Wm S. Bennett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 19 40 at 6:22 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death

Arterio Sclerosis

DURATION

2 months

Due to.....

Due to.....

Other conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

Wm S. Bennett M. D. or other
Address Princeton, Md. to signed 3/8-45

UNITED STATES DEPARTMENT OF JUSTICE

RECORDS SECTION

R.M.

APR 4 1945

BUREAU V.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03206

Reg. Dist. No. 265

1. PLACE OF DEATH:

County... Somerset
 City or town... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... MD County... Somerset
 City or town... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... RFD
 (If rural, give LOCATION)
 2.(a) If veteran, name war... none

3. (a) FULL NAME

John F. Sterling

3. (b) Social Security Number

none

4. Sex
male5. Color or race
white6. (a) Single, married, widowed, or divorced
widower6. (b) Name of husband or wife... Hettie L.7. Birth date of deceased (mo., day, yr.) January 6, 1863

8. (c) If alive, give age... years

8. AGE: Years 82 Months 2 Days 24 If less than one day
.....hrs.min.9. Birthplace... Crisfield, Md.
(Town, county, and state)10. Usual occupation... Farmer
Self

11. Industry or business

12. Name... Hance Sterling13. Birthplace... Md.14. Maiden name... Harriett Bedsworth15. Birthplace... Md.16. Informant... Emma SterlingAddress... Crisfield, Md.17. Burial Date thereof... April 2, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Mariners
Crisfield, Md.Location... Howard H. Hubbard18. Funeral director... 506 Main St., Crisfield, Md.

Address

19. 3/31/45 19 6, E. Calders, m.d.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 30, 1945 19 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Was Dead When

Immediate cause of death

Strokes Called
Coronary
Occlusion

DURATION

Other conditions

(If signed by physician within 1 month)

Major findings of operation

DEPUTY MEDICAL EXAMINER

FOR SOMERSET COUNTY, MD.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Natural Cause

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

Wm H. Coulbourn
Crisfield Md M. D. Brother
Address Date signed 3/31/45

RECEIVED

APR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 320

CERTIFICATE OF DEATH

Reg. Dist. No. 03207 265

1. PLACE OF DEATH: County..... <u>Somerset</u> City or town..... <u>Crisfield</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>life</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?.....		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Md.</u> County..... <u>Somerset</u> City or town..... <u>Crisfield</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>R.F.D.</u> (If rural, give LOCATION) 2.(a) If veteran, name war..... <u>none</u>	
---	--	---	--

3. (a) FULL NAME <u>William A. Sterling</u>	3. (b) Social Security Number <u>none</u>
---	---

4. Sex <u>male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife..... <u>Addie Mae</u>
--

6. (c) If alive, give age..... <u>76</u> years
--

7. Birth date of deceased (mo., day, yr.) <u>March 11, 1863</u>

8. AGE:	Years	Months	Days	If less than one day
<u>82</u>			<u>7</u>hrs.min.

9. Birthplace..... <u>Somerset Co., Md.</u> (Town, county, and state)
--

10. Usual occupation..... <u>Retired Auto salesman</u>
--

11. Industry or business..... <u>self</u>

12. Name..... <u>Josiah Sterling</u>

13. Birthplace..... <u>Md.</u>

14. Maiden name..... <u>Catherine DeNight</u>

15. Birthplace..... <u>Pa.</u>

16. Informant..... <u>Cullen Sterling</u>

Address..... <u>Crisfield, Md.</u>

17. <u>burial</u> (Burial, cremation, or removal. Which?)	Date thereof..... <u>3/19/45</u> (month) (day) (year)
--	--

Cemetery or crematory..... <u>Asbury</u>
--

Location..... <u>Crisfield, Md.</u>

Funeral director..... <u>Howard H. Hubbard</u>
--

Address..... <u>306 Main St., Crisfield, Md.</u>
--

Address..... <u>3/19/45</u>

19. (Date rec'd by registrar)..... <u>3/19/45</u>

19. (Date rec'd by registrar)..... <u>C.E. Collins</u>
--

MEDICAL CERTIFICATION 20. DATE OF DEATH..... <u>March 17, 1945</u> ..19..... at <u>6.10 A.</u>	
--	--

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>2/11/45</u> to <u>March 7</u> and that I last saw him/her alive on <u>March 17</u> .

Immediate cause of death..... <u>Phlebotomy</u>	DURATION
---	----------

Due to..... <u>Myocardial infarction</u>
--

Due to..... <u>Myocardial infarction</u>
--

Other conditions..... <u>Myocardial infarction</u>
--

(Include pregnancy within 8 months of death)
--

Major findings of operations..... <u>none</u>

Date of op.....

Autopsy results..... <u>none</u>

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....	Date of.....
-------------------------------------	--------------

Where did injury occur?.....	(City or town)	(County)	(State)
------------------------------	----------------	----------	---------

Injured at home, farm, industry, public place (where?).....

Means of injury.....	Injured at work?
----------------------	------------------

23. SIGNATURE..... <u>C.F. Somers</u>

M. D. or other

Address..... <u>Crisfield, Md.</u>	Date signed..... <u>3/18/45</u>
------------------------------------	---------------------------------

RECEIVED
JUN 9 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03208

265

1. PLACE OF DEATH: County..... Somerset City or town..... Crisfield (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... 5 yrs Hospital, institution, or street address where death occurred: How long in hospital or institution?.....		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... Md County..... Somerset City or town..... Crisfield Md (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....	
3.(a) FULL NAME Alfred Toulson		3.(b) Social Security Number 213-18-4614	
4. Sex Male	5. Color or race Negro	6.(a) Single, married, widowed, or divorced Married	
6.(b) Name of husband or wife..... Josephine Toulson			
6.(c) If alive, give age..... 47 years			
7. Birth date of deceased (mo., day, yr.) Nov 3 1896			
8. AGE: Years 48	Months 4	Days 4	If less than one day hrs. min.
9. Birthplace..... Unknown Virginia (Town, county, and state)			
10. Usual occupation..... Laborer			
11. Industry or business..... Seafood House			
FATHER	12. Name..... Zeb Toulson		
	13. Birthplace..... ? Virginia		
MOTHER	14. Maiden name..... Sarah Green		
	15. Birthplace..... ? Virginia		
16. Informant..... Josephine Toulson Address..... So. Street, Crisfield Md			
17. Burial Date thereof..... Nov 11 1945 (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory..... Asbury cemetery Location..... Crisfield Md Funeral director..... John A Bradshaw Address..... Crisfield Md			
18. Funeral director..... John A Bradshaw Address..... Crisfield Md			
19. 3/10/45 19 68 Collins, M.D. (Date rec'd by registrar) Registrar			
MEDICAL CERTIFICATION			
20. DATE OF DEATH..... 3/7 19 45 at LA M			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/27/44 to 3/7 19 45 and that I last saw him alive on 3/6/45 19 45			
Immediate cause of death..... Myocardial insufficiency			
Due to..... Edema			
Due to.....			
Other conditions.....			
(Include pregnancy within 3 months of death)			
Major findings of operations.....			
Autopsy results.....			
PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury..... Injured at work? Signature..... W. J. Markley, M.D. Address..... Crisfield Md Date signed..... 3/19/45			

RECEIVED
MAR 29 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 03209 268

1. PLACE OF DEATH:

County Somerset
 City or town Chance MD
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? hopeless
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset
 City or town Chance
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Virginia Tyler

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Deceased

7. Birth date of deceased (mo., day, yr.)

March 13 1865

8. (c) If alive, give age years

8. AGE:

80 Years 1 Months 1 Days If less than one day hrs. min.

9. Birthplace

Chance MD
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Benjamin Jones

12. Name

Chapman Jones

13. Birthplace

Chapman Jones

14. Maiden name

Chance

15. Birthplace

Edwin Tyler

16. Informant

Chance

Address

Burial

17. (Burial, cremation, or removal, which?)

Date thereof March 16-45

Cemetery or crematory

Chance M. E.

Location

Chance MD

18. Funeral director

Deeds Island

Address

March 16 1945

19. (Date rec'd by registrar)

Rosa Webster

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 14th 1945 at 1045 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on

19

Immediate cause of death

Myocardial

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Therese

M. D. or other

Address Princess Anne MD Date signed

CERTIFICATE OF DEATH

RECEIVED
APR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03219

269

1. PLACE OF DEATH:

County SomersetCity or town Orville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Wallace

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Allie M. Wallace

7. Birth date of

deceased (mo., day, yr.)

March 15 18746. (c) If alive, give age 66 years

8. AGE:

Years

Months

Days

If less than one day

7116hrs.min.

9. Birthplace

Orville, Maryland
(Town, county, and state)

10. Usual occupation

Waterman

11. Industry or business

FATHER

12. Name

William W. Wallace

13. Birthplace

Orville, Maryland

MOTHER

14. Maiden name

Hettie Windsor

15. Birthplace

Orville, Maryland

16. Informant

William W. Badgerworth

Address

Orville, Maryland

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

April 2 1940
(month) (day) (year)

Cemetery or crematory

J. O. M. Cemetery

Location

Orville, Maryland

18. Funeral director

Wale Washfield

Address

Princess Anne, Md.

19. (Date rec'd by registrar)

April 2 1940

19. (Date)

Wm. D. Bennett

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Somerset

City or town

Orville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 3119. 40at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him

alive on

19. 19

Immediate cause of death

Coronary Arteriosclerosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Smith

M. D. or other

Address

Princess Anne, Md.

Date signed

4-2-40

UNITED STATES DEPARTMENT OF HEALTH

AND HUMAN SERVICES

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

NO. 111-111111

RECEIVED
APR 26 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122-2

CERTIFICATE OF DEATH

03211

Reg. Dist. No. 260

1. PLACE OF DEATH:

County Somerset
 City or town Mt Vernon, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Glen Wallace

4. Sex

M

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Anna Mae Wallace

7. Birth date of

deceased (mo., day, yr.)

November 8, 1909

8. AGE:

Years

36

Months

4

Days

20

If less than one day

hrs.min.

9. Birthplace

Mt Vernon, Md.

(Town, county, and State)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 3/31

1945

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

220-11-8462

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 28, 1945 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 28, 1945 to March 28, 1945

and that I last saw him alive on

March 28, 1945

Immediate cause of death

Acute Gastro Enteritis

DURATION

6-8 mths

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 3-30-45

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APR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

03212

Reg. Dist. No. 265

1. PLACE OF DEATH: Somerset
County..... Crisfield
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 2 yrs
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... N Y County..... Unknown
City or town..... Richmond Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war..... ✓

3. (a) FULL NAME
John Ward

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Jane Lane Ward
B. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 16 1871
8. AGE: Years 73 Months 10 Days 3 If less than one day hrs. min.

9. Birthplace Crisfield Somerset Maryland
(Town, county, and state)
10. Usual occupation Retired waterman
11. Industry or business

12. Name Charles Ward
13. Birthplace Crisfield Md
14. Maiden name Nancy Snead Salisbury
15. Birthplace Crisfield Md
16. Informant Mrs Sarah Moore
Address Crisfield Md

17. Burial Date thereof Feb 22 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Crisfield cemetery
Location Crisfield Md
18. Funeral director John A Bradshaw
Address Crisfield Md

19. 3/21/45 19 C. E. Collins M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945 at 1:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
He was dead when I
and that I last saw him alive on
Immediate cause of death was called

Heart Attack
Due to fell in Water
Due to Accidental
Other conditions Drowned
(Include pregnancy within 3 months of death)

Major findings of operations.....
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged medically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accidental Date of 3/19/45
Where did injury occur Crisfield (County) Md
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE William H. Conbourne M.D.
Address Crisfield Md Date signed 3/21/45

DURATION
DEPUTY MEDICAL EXAMINER
FOR SOMERSET COUNTY, MD.

CERTIFICATE OF DEATH

NAME OF DECEASED

CITY

AGE

SEX

RACE

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

TEMPORARY CAUSE

CAUSE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

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RECEIVED
APR 6 1945
BUREAU V.S.

RECEIVED
APR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1372

CERTIFICATE OF DEATH

03213

Reg. Dist. No. 260

1. PLACE OF DEATH:

County SomersetCity or town Westover Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Westover Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary E. Widdowson

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widow

8.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 18678. AGE: Years 78 Months 1 Days 4 If less than one day _____ hrs. _____ min.9. Birthplace Yonkers, Pennsylvania
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name John I. Rowe13. Birthplace Yonkers, Penna.14. Maiden name Lucinda Bence15. Birthplace Yonkers, Penna.16. Informant Cloyd WiddowsonAddress Princess Anne, Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof March 30, 1945
(month) (day) (year)Cemetery or crematory Protestant CemeteryLocation Princess Anne, Md.18. Funeral director Dale D. DahlAddress Princess Anne, Md.19. 3/30 1945 g. Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945, at 12 30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1945, to March 28 1945, and that I last saw her alive on March 27 1945.Immediate cause of death Acute old age DURATION 3 wksDue to Central Nervous System 3 wksDue to Senile ArteriosclerosisOther conditions Chronic old age

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where)? _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Guy O. Doolittle, M.D. M. D. or other _____Address Princess Anne, Md. Date signed March 28, 1945

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 6 1945

BUREAU V.S.